Rehabilitation Assessment Form

BlueCross BlueShield Kansas

Complete this form and fax it to **877-218-9089**. Include hospital admission H&P and any PM&R consultation notes.

Section 1 – Assessment Type/Coverage

CLEAR DATA

Assessment Type: ☐ Initial Assessment ☐ Reassessment

Plan: ☐ Blue Medicare Advantage (PPO) ☐ Blue Medicare Advantage Comprehensive (PPO)

Section 2 – Member/Facility Information

Member Name _____ Age _____

Authorization Number _____

Contract Number _____

Facility Reviewer for Updates _____

Admitting Facility & NPI _____

Phone Number (_____) _____-_____

Fax Number (_____) _____-_____

Admission Type: ☐ SNF ☐ IP Rehab

Team Conference Day _____

Section 3 – Admission Information (Complete this section for the initial assessment only)

Admission Date (Facility) _____/_____/_____

Prior Level of Function (Home) _____

Facility Doctor Name (First and Last Name) & NPI _____

Home Configuration _____

ICD-10 Code _____

PMH _____

Number of Steps at Entry _____

PSH _____

Height _____ Weight _____

Location of Bed _____

Location of Bath _____

Section 4 – Clinical Information/Basics

Vital Signs: T _____ P _____ R _____ BP _____

O2 Delivery: Type _____ Sats _____

Cognition/A&O: ☐ x1 ☐ x2 ☐ x3

Respiratory Tx: ☐ Yes ☐ No

Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy

Trach: Type _____ Size _____

Bladder: ☐ Continent ☐ Incontinent ☐ Cath Type _____

Suction Frequency/24H: _____

Diet: ☐ NPO or ☐ Type _____

Pain Location/Mgt: _____

Tube Feeding: ☐ Formula Rate _____

Section 5 – Mobility Current Functioning (Use Key in Section 11)

Bed Mobility: _____

Transfers: _____

Gait/Distance: _____

Assist Level: _____

Assistive Device: ☐ None or ☐ _____ (Type)

Stairs (ascending, descending):

☐ Not applicable ☐ Assist needed _____ (Type)

Number of stairs: _____

Handrails: _____

Assist needed: _____

WC Mobility: _____

Distance: _____

Assist needed: _____

Section 6 – Clinical Information/Medications

IV medications, with ending dates:

Vascular Access:

Significant medications that affect functioning:

Section 7 – Self-Care Current Functioning (Use Key in Section 11)

Feeding: _____

Grooming: _____

Bathing: _____ (UE) _____ (LE)

Dressing: _____ (UE) _____ (LE)

Toileting/Hygiene Mgt: _____

ADL Transfers: _____

Comments:

Section 8 – Clinical Information/Skin Status

Skin Status: ☐ Intact

If not intact, complete fields below and add pages as needed.

Wound or Incision/Location 1 – Stage: _____

Size (L x W x D in cm): _____

Treatment: _____

Wound or Incision/Location 2 – Stage: _____

Size (L x W x D in cm): _____

Treatment: _____

Section 9 – Speech Therapy Current Status

☐ None

☐ Dysphagia Eval./Modified Barium Swallow

Results/Aspiration Risk/Recommendations:

Please continue on the next page.

Section 10 – Discharge (D/C) Plans

_____ /_____ /_____
D/C Date (Tentative)

D/C with: ☐ HHC Provider _____

☐ OP Provider _____

D/C Equipment (prior auth required):

_____

D/C Destination: _____

Member to live with: _____

Supervision Needs:

D/C Goals:

Section 11 – Key for Mobility and Self-Care Functioning

I	Independent
MI	Modified Independent
Sup	Supervision
SBA	Standby Assist
CGA	Contact Guard Assist

Min	Minimal
Mod	Moderate
Max	Maximum
Total	Total Assist

Section 12 – Additional Notes

Complete this form and fax it to **866-809-1370**. Include hospital admission H&P and any PM&R consultation notes.

_____
Member Name

_____
Contract Number

_____
Admitting Facility

_____ /_____ /_____
Today's Date